

VERONICA HAMILTON-DEELEY DL,
LL.B.
Her Majesty's Senior Coroner
for the City of Brighton & Hove



THE CORONER'S OFFICE
WOODVALE, LEWES ROAD
BRIGHTON
BN2 3QB

Assistant Coroners
CATHARINE PALMER LL.B (HONS)
KAREN HENDERSON, BSC,BM,MRCPI,FRC...
GILVA D.J.TISSHAW, BA(LAW)HONS

Telephone: Brighton (01273) 292046
Fax: Brighton (01273) 292047

CORONERS SOCIETY OF ENGLAND AND WALES

ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	<p>THIS REPORT IS BEING SENT TO:</p> <p>1. Ms Evelyn Barker, Chief Executive, Brighton and Sussex University Hospitals NHS Trust</p>
1	<p>CORONER</p> <p>I am Veronica HAMILTON-DEELEY, Senior Coroner, for the City of Brighton and Hove</p>
2	<p>CORONER'S LEGAL POWERS</p> <p>I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.</p>
3	<p>INVESTIGATION and INQUEST</p> <p>On Ninth December 2016 I commenced an investigation into the death of Patricia Margherita WEBB. The investigation concluded at the end of the inquest on Twelfth April, 2017. The conclusion of the inquest was a NARRATIVE CONCLUSION.</p>
4	<p>CIRCUMSTANCES OF THE DEATH</p> <p>[REDACTED]</p> <p>Mrs Webb who was an 86 year old woman had been admitted to hospital on the 26th August, 2016 she was moved between two of the cardiology wards and finally was on Emerald Ward. She had six falls during her time in hospital from admission until the 29th October when she fractured her hip in the sixth fall (the fourth fall on Emerald Ward).</p> <p>The Record of Inquest in the Narrative Conclusion sets out my anxieties about this lady who fell because she was so mobile.</p>

VERONICA HAMILTON-DEELEY DL,
LL.B.
Her Majesty's Senior Coroner
for the City of Brighton & Hove



THE CORONER'S OFFICE
WOODVALE, LEWES ROAD
BRIGHTON
BN2 3QB

Assistant Coroners
CATHARINE PALMER LL.B (HONS)
KAREN HENDERSON, BSC, BM, MRCPI, FRC...
GILVA D.J. TISSHAW, BA (LAW) HONS

Telephone: Brighton (01273) 292046
Fax: Brighton (01273) 292047

5

CORONER'S CONCERNS

During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you.

The **MATTERS OF CONCERN** are as follows. –

- (1) At the Inquest I was told that on Emerald Ward the Nursing staff have a higher awareness of the risk of falls because so many of their patients are at high risk. However, they provide no specialising. Presumably the rationale for this is that they are extremely good at their job and are able to take care of their patients without specialising. Demonstrably in Mrs Webb's case this did not happen.
- (2) There was a plan in mid-September put in place by the Dementia Nurse for Mrs Webb to have increased levels of observation, for her to be engaged in meaningful activity and for allowing her to be mobile but using non slip footwear and a mobility aid.
With regard to the observations I really could not see any evidence that this was giving her enhanced protection. When analysing the falls and their timing it was clear that they always happened early in the morning and often round about the end of the night shift and the start of the day shift when clearly this particular lady was more vulnerable because I suppose she was more active, possibly also if she had been in bed for most of the night she might have been less safely mobile. It's a shame that this pattern was not observed and arrangements put in place to keep a particular eye on her around this period of time.
With regard to meaningful activity it never appeared in the notes following the mid-September plan and since it wasn't in the notes I found no evidence that it happened. I would suggest that on each change of shift the meaningful activity which the patient has engaged in is recorded and noted so that if there is something that he or she finds particularly absorbing this activity can be offered at times of particular vulnerability.
With regard to mobilising, I fully appreciate that the wandering patient who is mobile is at particular risk and I also appreciate the difficulty that might be encountered when trying to persuade such a patient to use a mobility aid. Non slip footwear however, is surely much easier to provide. I know that the hospital footwear comprises 'short socklets' in different sizes (thus the right size is always difficult to obtain) with non-slip soles. I was told that these can shift round on the foot so that the sole perhaps rides round to the top of the foot meaning the socklet then becomes dangerous.

VERONICA HAMILTON-DEELEY DL,
LL.B.
Her Majesty's Senior Coroner
for the City of Brighton & Hove



THE CORONER'S OFFICE
WOODVALE, LEWES ROAD
BRIGHTON
BN2 3QB

Assistant Coroners
CATHARINE PALMER LL.B (HONS)
KAREN HENDERSON, BSC, BM, MRCPI, FRC...
GILVA D.J. TISSHAW, BA (LAW) HONS

Telephone: Brighton (01273) 292046
Fax: Brighton (01273) 292047

Wouldn't it be an idea to see whether proper slippers can be sourced. Perhaps there is a local firm who would like to provide these – it would be a challenge to make them reusable or alternatively if they are cheap enough to be disposed of after use by one patient. Is it worthwhile liaising with South East Coast Ambulance asking them to encourage patients being brought to hospital to bring their own slippers in exactly the same way as they bring their own medications. Whilst I appreciate many of the slippers bought in by patients will be unsuitable by the same token many will be perfectly acceptable.

- (3) In the Royal Sussex County Hospital, I understand there is to be or already taking place a trial of 'buzzer alerts' for Nurses – I am sure this is an extremely good idea but feel that it may be more profitable to be proactive rather than reactive.
- (4) I was also told that patients being nursed in side rooms and in the balcony area can produce problems for the nursing staff who as I understand it are sometimes short staffed. It may be that when the new building is completed there will be less hidden areas but how many falls will take place between now and 2021 when it is hoped that the building may be open?
- (5) The final area which concerns me is handover. It is such an important time for exchange of information so that appropriate care can be given to each individual patient and from what I heard at Mrs Webb's Inquest the handover relies more and more on the notes and the notes are relying more and more on tick boxes which are simply not adequate to deal with the individualities of each patient.
- (6) During the course of this Inquest I heard that it was very difficult to obtain extra resources for some of the things which were discussed. I suggested that possibly local appeals could be useful and maybe even an article in the local newspaper engaging the local community in an important Ward given that it deals with many elderly demented patients waiting for discharge to ongoing care within the community.
- (7) Discharge itself in the MRFD patient must be speeded up.

These matters which were raised in Mrs Webb's Inquest and which have been raised by me in this Regulation 28 Report are truly intended to be helpful but may mean that some of the thinking around forms and engagement of nurses with patients rather than engagement by nurses with patients' notes must be more prominent.

VERONICA HAMILTON-DEELEY DL,
LL.B.
Her Majesty's Senior Coroner
for the City of Brighton & Hove



THE CORONER'S OFFICE
WOODVALE, LEWES ROAD
BRIGHTON
BN2 3QB

Assistant Coroners
CATHARINE PALMER LL.B (HONS)
KAREN HENDERSON, BSC, BM, MRCPI, FRC...
GILVA D.J. TISSHAW, BA (LAW) HONS

Telephone: Brighton (01273) 292046
Fax: Brighton (01273) 292047

6	<p>ACTION SHOULD BE TAKEN</p> <p>In my opinion action should be taken to prevent future deaths and I believe you AND your organisation have the power to take such action.</p>
7	<p>YOUR RESPONSE</p> <p>You are under a duty to respond to this report within 56 days of the date of this report, namely by 4TH July 2017. I, the coroner may extend the period.</p> <p>Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise you must explain why no action is proposed.</p>
8	<p>COPIES and PUBLICATION</p> <p>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons</p> <ol style="list-style-type: none"> 1. [REDACTED] Medico-Legal Services 2. [REDACTED] Head of Safety 3. [REDACTED] Consultant, Elderly Medicine 4. [REDACTED] Lead Nurse for Discharge and Partnerships 5. [REDACTED] Ward Manager, Emerald Ward 6. Secretary of State for Health, Department of Health 7. Simon Stevens – Chief Executive NHS England <p>I am also under a duty to send the Chief Coroner a copy of your response.</p> <p>The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.</p>
9	<p>Date: 20TH April 2017</p> <p>SIGNED BY:</p> <p><i>Veronica Hamilton-Deeley</i></p> <p>Senior Coroner Brighton and Hove</p>